**2012 Planning Activities Report Form (Part B: Policy and Planning)**
Erie County Dept. of Mental Health (70290)
Certified: William Fremgen (6/1/11)

Consult the LSP Guidelines for additional guidance on completing this exercise.

**1. Recovery Support Awareness Efforts (OASAS)**

In the wake of the court ruling in DeStefano v. Emergency Housing Group in 2001, OASAS issued a local services bulletin LSB 2002-05 clarifying what providers could and could not do regarding attendance at AA meetings or other community-based and faith-based self-help meetings. Refer to the discussion about this issue in the guidelines for additional context before answering Question 1a below. Among the variety of recovery support services that may be available in your county, Recovery Coaching and Telephone Recovery Support have each shown to have success for people in early recovery while still in treatment. OASAS is trying to increase awareness and use of these two recovery supports.

**1a.** What effort has the county made, or is making, to ensure that providers understand the guidance provided in LSB 2002-05 and are connecting individuals to community and faith-based recovery supports such as AA or other self-help groups while they are still participating in treatment?

The Department has always endorsed provider and community efforts to promote the utilization of appropriate self-help resources. Moreover, Chemical dependency service providers under contract with the Department are reminded of the necessity to comply with OASAS policies and procedures by the terms of their contracts and, by the Department's assertive contract management practices.

**1b.** What effort has the county made, or is making, to increase the awareness of providers of Recovery Coaching and Telephone Recovery Support these two recovery support activities?

Prior to the initiation of this planning exercise, the Department has not received nor been made aware of active promotion and/or training by OASAS in regard to these activities. Accordingly, at least due to this lack of outreach by OASAS or oversight by the Department, there has to date been no effort in this regard.

As a result of this question, the Department will investigate to obtain clarification of OASAS requirements and expectations. Moreover, the Department will include in its planning process consideration of integrating these support activities in its system development and coordination responsibilities.

**2. Medicaid Redesign (Optional)**

In January, Governor Cuomo established a Medicaid Redesign Team. Its objective is to find ways to reduce costs and increase quality and efficiency in the Medicaid program. Part of this effort includes seeking ideas from the public at large, as well as experts in health care delivery and insurance, the health care workforce, economics, business, consumer rights and other relevant areas. These guidelines provide counties with an additional opportunity to provide input into this process. Resources you may find particularly helpful in completing this item include: OASAS Detailed Medicaid Recipient Profiles (2007-09), OMH County Mental Health Profiles (Adult Medicaid Expenditures).

**2a.** What specific system or program reforms/changes have you enacted, or are you proposing to enact during the reporting period, that will improve quality and/or reduce costs to the Medicaid program?

Erie County is in the process of implementing the following in preparation for a Managed Behavioral Health Care environment:

- Adult SPOA (Single Point of Access and Accountability) reform
  - identifying, triaging and engaging high cost individuals
  - utilization management focused on reducing the length stay in care coordination in order to better serve high need high risk individuals
  - begin implementing the Critical Time Intervention model
- Reshaping non-licensed services for improved focus and accountibilty
- Reshaping services for Older Adults

SPOA Reform

Using 2008 Medicaid data, the most recent year available at the time of analysis), ICM/SCM/Blended Case Management programs potentially save $4,116 in Medicaid for each individual served, and ACT potentially saves $3,960 in Medicaid per person served. As the SPOA is moving towards serving high need high cost individuals earlier in their trajectory, savings will increase.

We are planning to implement Critical Time Intervention as a key component of SPOA reform and have begun work with Dr. Dan Herman. Critical Time Intervention (CTI) is a nine-month case management intervention designed to enhance continuity of support for persons with severe mental illness during periods of transition. Such periods may include the months following discharge from hospitals, jails and other institutions, the transition from homelessness to housing, or the transition between different levels of treatment and support.

CTI operates in two ways: by strengthening the individual's long-term ties to services, family, and friends; and by providing emotional and practical support during the critical time of transition. An important aspect of CTI is that post-discharge services are delivered by a worker who has established a relationship with the client before discharge. CTI shares with long-term assertive community treatment models a focus on promoting in vivo development of independent living skills and building effective support networks in the community. The emphasis, however, is on maintaining continuity of care during the critical period of transition while primary responsibility gradually passes to existing community supports that will remain in place after the intervention ends. Such an approach, we believe, increases the likelihood that the impact of a time-limited intervention will persist beyond its actual endpoint, which is the primary goal of CTI.

CTI is delivered in three phases, each of which lasts approximately three months (see table). Phase one--transition to the community--focuses on providing intensive support and assessing the resources that exist for the transition of care to community providers. Ideally, the CTI worker will have already begun to engage the client in a working relationship before he or she leaves the institutional setting. This is important because the worker will build on this relationship to effectively support the client following discharge from the institution. The CTI worker generally makes detailed arrangements in only the handful of areas seen as most critical for community survival of that individual. Phase two—try out-- is devoted to testing and adjusting the systems of support that were developed during phase one. By now, community providers will have assumed primary responsibility for delivering support and services, and the CTI worker can focus on assessing the degree to which this support system is functioning as planned. In this phase, the worker will intervene only when modification in the system is needed or when a crisis occurs. Phase

three—transfer of care-- focuses on completing the transfer of responsibility to community resources that will provide long-term support. One way in which CTI differs from services typically available during transitional periods is that the transfer of care process is not abrupt; instead, it represents the culmination of work occurring over the full nine months.

CTI is an evidence-based model that has been tested in several rigorously designed trials. It is listed in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).

Further information is available at www.criticaltime.org

Reshaping Non-licensed Services

We had been funding a wide range of non-licensed recovery oriented services, increasing funding through time on an incremental basis. Using the RFP process, we funded specific services with the following core components and accountability measures:

- Credentialed benefit advisement
- Support for work
- Parenting support
- Financial literacy
- Live coaching
- and Recovery Center, for all components

Medicaid savings should result from our increasing focus on serving high need/high risk and emerging populations, many of whom are high Medicaid users.

Older Adult Reform

We had been funding services for older adults based on what we had historically been funding. As part of our RFP process, we evaluated these services and then focused on a target population at risk of nursing home or institutional placement as a result of the following:

- mental health symptoms
- co-morbid medical issues that complicate treatment/effect long term stability
- co-occurring substance abuse
- poverty presenting a barrier to accessing needed and appropriate services, supports and/or resuources

We are implementing these newly awarded services in strong partnership with our Department of Senior Services and are using their information system to track and improve performance. Medicaid savings should result occur as a result of diversion from nursing homes and other institutional placements.

**2b.** What specific regulatory or administrative changes have you implemented locally (in partnership with your Medicaid Managed Care companies or local Commissioners of Social Services/Human Services) to lower costs and/or improve quality within the Medicaid program?

Complex Care Management (CCM) - in partnership with Beacon Health Strategies and the New York Care Coordination Program

Individuals are invited to participate in the CCM program based on health care services that they have used. This program is designed for individuals who:

- Have experienced frequent emergency room visits or admissions to the hospital for medical, mental health or substance abuse issues;
- May have had difficulty finding effective services and supports; and/or
- Might benefit from Care Coordination.

If an individual chooses to participate in the CCM program, their normative length of stay will be three to six months. During this time, the program will assist to:

- Identify health care providers and make sure they have appointments for services;
- Identify what supports they need/desire and develop these supports in the community of their choice; and
- ensure an integrated and coordinated plan of care is delivered to promote wellness and recovery.

SPOA Reform - Utilization Management Targeted to Long Length of Stay in Targeted Case Management Programs

Using data from the New York Care Coordination Program, enrollmeent in ICM/SCM/BCM programs saves approximately $4,100 in Medicaid per year, using current models. We are beginning to use utilization management practices in order to serve high risk, high cost individuals, resulting in improved savings.

The Department of Mental Health implemented a Six Sigma project using DMAIC tools to reduce the variation in length of stay of individuals in Care Coordination, and as a result, reduce the average length of stay in order to serve the emerging high need, high risk population. In the initial stages of this project, we realized that there is a large variation in length of stay for individuals in Intensive Case Management, Supporive Case Management and Blended Case Management programs but the length of stay for individuals in Assertive Community Treatment programs does not have much variation i.e. the length of stay is long for most enrolled individuals.

During the project, we reviewed the case records of individuals with the longest individuals with the longest lengths of stay in ICM, SCM and BCM programs. The average length of stay for these 28 individuals was 5.23 years. The most frequently cited problems at admission for these individuals was inability to maintain stable housing, and frequent arrests. At the time of review, individuals were generally linked to treatment, housing. Most were also liked to community supports, natural supports and medical care but the linkages were less clearly displayed in the charts. Six of the individuals who we thought were open were, in fact, closed.

As a result of our initial work:

- The reduction in variation in length of stay was reduced by a statistically significant level, from 538 days to 432 days
- The reduction in mean length of stay was reduced but not by a statistically significant level yet, from 451 days to 413 days

Adult SPOA Reform - Targeting High Users of Medicaid

As part of the previously described SPOA reform, we targeted Erie County Adults who had used Mental Health services and who, in a three month period, had a Mental Health hospital admission and a previous Behavioral or Physical Health admission in the prior 90 days, excluding

individuals with nursing home or prior OPWDD claims. The source of data was Erie County Fee for Service Medicaid. This data run resulted in 192 individuals who we are defining as high cost/high need. The total cost of these 192 individuals in 2010 was $7,827,745.

| | 2010 Cost |
|---|---|
| Substance abuse | $ 414,334 |
| Mental Health | $ 4,546,455 |
| OPWDD | $ 59 |
| Physical health | $ 2,203,908 |
| Pharmacy | $ 662,989 |
| Total | $ 7,827,745 |
| | |
| Average Cost per person | $ 40,770 |
| Standard deviation | $ 33,995 |
| Mean Cost per person | $ 31,390 |
| Highest Cost person | $ 195,135 |

The SPOA reviewed the highest cost individuals from this group to triage outreach and engagement by Care Coordination Agencies, and are including the most recent contact information that we available. With the Agencies, we have developed a process for referral from the SPOA and created a tool to track engagement activities /timeframes. We are currently evaluating practices used by Care Coordination Agencies in the engagement process in order develop timing and practice standards.
Adult SPOA reform will be moving towards

- Shifting from “individual meets admission criteria” towards assessment and triage to ensure right person, right service, right time and right length of time.
- Utilization management throughout the SPOA/Care Coordination process i.e. front and back door management of services
- Timely access
- Consistent practice across Agencies/Programs
- Data driven decision making
- Predictive modeling for high cost individuals.

These interventions not only need to pay for themselves, they will need to result in cost savings

**2c.** What current elements of your local Medicaid program or system of care do you find have truly worked to control costs and enhance quality, and that you feel should be preserved or expanded?

The following (also described below) have contributed to enhancement of quality and controlling costs:

- Practice to outcome models / fidelity to practice
- Quality improvement mechanisms
- Utilization Management
- Performance Accountability
- Access to real time data that is used to monitor practice to outcomes, quality improvement, utilization management and performance accountability
- Sharing aggregate data and data dashboards with partners

We have taken this approach most intensively with Care Coordination, both for Children/Youth and Adults. Cost savings have been calculated using only Medicaid fee for service data and OCFS Residential Treatment Center data. However, we do not have access to encounter data from Medicaid Managed Care, an increasingly important payor source.

In order to enhance these improvements and also extend gains to additional program categories, we are requesting expanded access to data such as:

- Medicaid managed care encounter data
- Data to identify individuals on a trajectory to high us
- Ability to drill down OMH data by race and ethnicity
- Ability to drill down OASAS data by provider

The Children’s System of Care that is funded through Medicaid as well as blended dollars has proven to be highly successful in having youth remain in their home community where it is developmentally appropriate to meet their needs in a family friendly, strength-based manner. Through a variety of community service contracts that are targeted to meet the needs of families we have been successful in reducing the number youth in out of home care. The length of time a youth remains in out of the home has also been reduced. We have been able to build a system of care that meets the needs of a large service-needing population in a more individualized fashion through identifying emerging trends of youth being placed on out of home care. Based on the identified unmet needs of youth, best practice services within the community are initiated.

With the adherence to utilization management and quality improvement practices, we have been able to sustain quality service delivery that focuses on prescribed matrix and benchmarks. These matrix and benchmarks have demonstrated successful interventions that support stabilization of a youth within their home. Moving toward informed decision making and reducing variability of practice among practitioners has produced a consist delivery of services for families within our community. This has resulted In a decrease of deeper system penetration for youth within our community.

The ability to have strong community partnerships within and outside of county government has brought a stronger focus on single point access of services for youth at risk of out of home care. Our community has built a strong vendor network system which allows for individualized service planning to meet the unmet needs and risk of families.

**2d.** What other recommendations do you propose to restructure the State Medicaid program that could "...achieve measurable improvement in

health outcomes, sustainable cost control and a more efficient administrative structure?"

The Erie County Department of Mental Health has found that the following approaches sustain measureable improvements in outcomes, sustain cost control and a more efficient administrative structure:

- Practice to outcome models / fidelity to practice
- Quality improvement mechanisms
- Utilization Management
- Performance Accountability
- Access to real time data that is used to monitor practice to outcomes, quality improvement, utilization management and performance accountability
- Sharing aggregate data and data dashboards with partners
- Dashboards based on cricial practices and outcomes
- Measure of physical and behavioral health integration
- Easing of 42 CFR which is a barrier to identifying and engaging high use individuals who could benefit from integrative, coordinated services

**3. Mandate Relief Redesign (Optional)**

In January, Governor Cuomo established a Mandate Relief Redesign Team to review unfunded and underfunded mandates imposed by the New York State government on school districts, local governments, and other local taxing districts. Unfunded and underfunded mandates drive up costs of schools, municipalities, and the property taxes that support them. The team is looking for ways to reduce the costs of mandated programs, identify mandates that are ineffective and outdated, and determine how school districts and local governments can have greater ability to control expenses. Given the objectives of the Mandate Relief Redesign Team described in these guidelines and the categories in which it is soliciting recommendations, identify potential mandate relief actions that you would like passed on to the team for consideration. For each recommendation, indicate whether the recommendation is for statutory or regulatory relief.

Statuatory Relief

We are recommending easing of 42 CFR which is a barrier to identifying and engaging high use individuals who could benefit from integrative, coordinated services

**4. Integration of Mental Hygiene Services (Optional)**

Given the current fiscal climate and dire budget projections for the years ahead, and given the ongoing efforts of LGUs to find more efficient and effective ways to meet the needs of people with co-occurring disabilities or to meet common needs across the different mental hygiene service systems, and given the priority of the governor to reduce the cost of needed services, identify potential strategies that will meet these objectives.

**4a.** Identify efforts the county has undertaken, or plans to undertake, that will lead to efficiencies and improved quality of care.

As part of our Adult SPOA Reform, the County is beginning to work with Dr. Dan Herman to implement the Critical Time Intervention Model for Targeted Case Management i.e. Intensive Case Management, Supportive Case Management and Blended Case Management. The County is also developing an information system that will capture critical elements for:

- fidelity to practice/practice to outcome
- quality improvement
- performance accountability

Also, Erie County has hired a Dual Recovery Coordinator (DRC). The DRC will assist the department to reframe dual recovery services (mental helath and chemical dependency) to include assessment and utilization of research informed practices, fidelity measures to practices, development of standardized performance measures and quality improvement planning/management related to the integration of care (further description in 2012 Multiple Disabilities Considerations Form).

**4b.** Identify strategies for service integration and care coordination.

The Erie County Department of Mental Health is working with the New York Care Coordination Program (NYCCP) to design and implement a specialized health home services program for children with serious emotional disturbance and adults with serious mental illness.

People with serious mental illness have complex physical health, behavioral health and social service needs. They are often poorly understood and poorly served by the mainstream health system. The cost of Medicaid and other government service to this group is extraordinarily high.

Erie County and the NYCCP has a documented record of success implementing person-centered service planning and care coordination programs in diverse service environments, with improved individual outcomes and significantly reduced Medicaid and other government costs. We wish to build on this success by fostering the development of specialty health home programs.

Specialty health homes would be a critical structural support for any managed care program that serves children with serious emotional disturbance or adults with serious mental illness. Our suggested approach to development of the program could be replicated statewide, allowing the State to ramp up quickly and take advantage of 90% federal financial participation for the first two years of operation.

**4c.** Identify potential strategies beyond the Medicaid redesign and mandate relief strategies covered in the two previous questions that can or should be employed at the state government level that will create a more favorable environment for the county and providers to provide more efficient and quality services.

The County's Adult SPOA work as focused primarily on Care Coordination. The County will welcome partnering with OMH to use a "right service to the right person at the right time for the right length of time" for ACT (Assertive Community Treatment) programs. This will ensure a more efficient and effective use of ACT slots.

The role of Local Governments moving forward in a Managed Behavioral Health environment is key to ensuring effective system management with respect to State and County issues. This includes

- Integration of Behavioral Health services with services provided in local communites that are not funded directly by Medicaid or the Behavioral Health sytem;
- Fidelity to community standards such as recovery, person centeredness and decreasing disproportionate minority representation in high intensity services;
- Monitoring lost to care both from quality and cost shifting standpoints; and
- Overseeing the local system of care i.e. adequacy, who is being serviced, quality of services and fidelity to Utilization Management standards